Adult Screening and Immunization Documentation Form

2010-2011 Seasonal Influenza Vaccination Program

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Name (Please Print):	**Sponsor's SSN:**

Circle answers to questions 1-11:

1	Do you currently feel sick or have a fever?	No	Yes
2	Have you ever had a serious reaction to a flu vaccine?	No	Yes
3	Do you have a history of Guillain-Barre Syndrome (GBS)?	No	Yes
4	Do you have an allergy to any of the following: eggs, egg protein, MSG, gentamicin, gelatin, arginine, neomycin, polymyxin B, thimerosal, formaldehyde, latex or other vaccine components?	No	Yes
5	Are you pregnant or planning to become pregnant in the next month?	No	Yes
6	Are you 50 years of age or older? **(If marked Yes, skip questions 7-11)**	No	Yes
7	Do you have a chronic health problem such as: asthma, heart disease, lung disease, kidney disease, metabolic disease (e.g., diabetes) or a blood disorder?	No	Yes
8	Do you have a weakened immune system because of HIV or another disease that affects the immune system, long-term high-dose steroid treatments, or cancer treatment with radiation or drugs?	No	Yes
9	Are you taking any prescription medicines to prevent or treat influenza? Have you taken any antivirals in the last 48 hours?	No	Yes
10	Do you live with or have close contact with severely immunocompromised individuals or someone who must be in a protective environment (such as transplant recipients?)	No	Yes
11	Have you received any vaccines within the last 30 days or do you plan to receive any vaccines in the next four weeks? (particularly live vaccines)	No	Yes
	If you are not sure that the person is registered or received services (pharmacy, lab, clinic, etc.) at Kenner Army Health Clinic, please complete the back of this sheet.		

"I have read or have had explained to me the information in the 2010-2011 Influenza Vaccine Information Statement (VIS). I have also had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine."

Signature: _____ Date: _____

Below to be completed by healthcare provider

☐ **Give injectable flu vaccine today**

☐ **Give intranasal flu vaccine today**

☐ **Do not administer flu vaccine today**

Vaccine Information Statement provided (check box)

☐ Inactivated Influenza Vaccine (TIV)

☐ Live, Attenuated Influenza Vaccine (LAIV)

Interviewer's Signature	**Date**

Vaccine Administered

☐ **Live Intranasal Influenza** (FluMist, MedImmune)
Lot # _____
Dose: 0.2 ml **Route: Intranasal**

☐ **Inactivated Influenza** (Fluzone, Sanofi-Pasteur)

☐ **Inactivated Influenza** (Fluzone High-Dose, Sanofi- Pasteur)

☐ **Inactivated Influenza** (Afluria, CSL)
Lot # _____
Dose: 0.5 ml **Route: IM** **Left / Right Deltoid**

Comments:

Administered by:	**Date**

Kenner Army Community Hospital
CHCS Patient Registration Form

SPONSOR (Please print and fill in all blanks)

LAST NAME: _____ **FIRST NAME:** _____ **M.I.:** ____

SPONSOR SSN: _____ - _____ - _____ **DOB:** (day/mo/yr): ____ / ____ / ____ **SPONSOR FMP:** 20

SPONSOR CATEGORY (Circle One):

A11 AD ARMY	A31 RET ARMY	___ **OFFICER**	**SEX:** (Circle One)
F11 AD AIR FORCE	F31 RET AIR FORCE		MALE/ FEMALE
N11 AD NAVY	N31 RET NAVY	___ **ENLISTED**	
M11 AD MARINES	M31 RET MARINES		
C11 AD COAST GRD	C11 RET COAST GRD		**RANK/GRADE:** ____/____
OTHER _____	OTHER _____		

PHONE: (Home) ( ) _____-_____ (Work) ( ) _____-_____

HOME ADDRESS: _____ **CITY:** _____

STATE/COUNTRY: _____ **ZIP:** _____

UNIT: _____ **DUTY PHONE:** _____

DUTY ADDRESS: _____ **MEDICAL RECORD LOCATION:** _____

LIST DRUG ALLERGIES & SIDE EFFECTS:
1. _____
2. _____
3. _____

OTHER HEALTH INSURANCE? YES NO
COMPANY: _____

SPOUSE (Please print and fill in all blanks)

LAST NAME: _____ **FIRST NAME:** _____ **M.I.:** ____

FMP (Check One):
___ 30 FIRST SPOUSE/FORMER SPOUSE
___ 31 2ND SPOUSE/FORMER SPOUSE
___ 32 3RD SPOUSE/FORMER SPOUSE

PATIENT CATEGORY (Circle One):

A41 DEP AD ARMY	A43 DEP RET ARMY	OTHER:
F41 DEP AD AIR FORCE	F43 DEP RET AIR FRC	_____
N41 DEP AD NAVY	N43 DEP RET NAVY	_____
M41 DEP AD MARINE	M43 DEP RET MARINE	
C41 DEP AD COAST GRD	C43 DEP RET COAST GRD	

DOB: (day/mo/yr): ____ / ____ / ____

SPOUSE SSN: _____ - _____ - _____ **SEX:** (Circle One) MALE/ FEMALE

____ **CHECK IF RESIDING WITH SPONSOR. IF NOT, PRINT ADDRESS BELOW.**

HOME ADDRESS: _____ **CITY:** _____

STATE/COUNTRY: _____ **ZIP:** _____ **MEDICAL RECORD LOCATION:** _____

PHONE: (Home) ( ) _____-_____ (Work) ( ) _____-_____

LIST DRUG ALLERGIES: & SIDE EFFECTS:
1. _____
2. _____
3. _____

OTHER HEALTH INSURANCE? YES NO
COMPANY: _____

(ADDITIONAL FAMILY MEMBERS ON REVERSE)